34.21 The Division of Audit will perform on-site audits, as considered appropriate, of the provider's financial and statistical records and systems.

34.22 The Division of Audit will base its selection of a facility for an on-site audit on factors such as but not limited to: length of time since last audit, changes in facility ownership, management, or organizational structure, random sampling, evidence or official complaints of financial irregularities, questions raised in the uniform desk review, failure to file a timely cost report without a satisfactory explanation, and prior experience.

34.23 The audit scope will be limited so as to avoid duplication of work performed by a facility's independent public accountant, provided such work is adequate to meet the Division of Audits requirements.

34.24 Upon completion of an audit, the Division of Audit shall review its draft findings and adjustments with the provider and issue a written summary of such findings.

35 SETTLEMENT OF COST REPORTS

35.1 Cost report determinations and decisions, otherwise final, may be reopened and corrected when the specific requirements set out below are met. The Division of Audits decision to reopen shall be based on: (1) new and material evidence submitted by the provider or discovered by the Department; or, (2) evidence of a clear and obvious material error.

35.2 Reopening means an affirmative action taken by the Division of Audit to re-examine the correctness of a determination or decision otherwise final. Such action may only be taken:

35.21 At the request of either the Department, or a provider within the applicable time period set out in paragraph 35.5; and,

35.22 When the reopening may have a material effect (more than one percent) on the provider's Medicaid rate payments.

35.3 A correction is a revision (adjustment) in the Division of Audits determination, otherwise final, which is made after a proper re-opening. A correction may be made by the Division, or the provider may be required to file an amended cost report.

35.4 A determination or decision may only be re-opened within three years from the date of notice containing the Division of Audits determination, or the date of a decision by the Commissioner or a court, except that no time limit shall apply in the event of fraud or misrepresentation.

35.5 The Division of Audit may also require or allow an amended cost report any time prior to a final audit settlement to correct material errors detected subsequent to the filing of the original cost report or to comply with applicable standards and regulations. Once a cost report is filed, however, the provider is bound by its elections. The Division of Audit shall not accept an amended cost report to avail the provider of an option it did not originally elect.

37 REIMBURSEMENT METHOD

37.1 Principle. Nursing care facilities will be reimbursed for services provided to recipients under the program based on a rate which the Department establishes on a prospective basis and determines is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated facility in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards.

37.2 Nursing facilities costs will be periodically rebased by the Department of Human Services when the Commissioner of the Department of Human Services determines that the rates paid to nursing facilities are in danger of failing to meet the residents needs or are in excess of costs which must be incurred by economic and efficient nursing facilities.

40 COST COMPONENTS

40.1 In the prospective case mix system of reimbursement, allowable costs are grouped into cost categories. The nature of the expenses dictate which costs are allowable under these Principles of Reimbursement. The costs shall be grouped into the following three cost categories:

40.11 Direct Care Costs,
40.12 Routine Costs, and
40.13 Fixed Costs.

Sections 41- 49 describe the cost centers in each of these categories, the limitations and allowable costs placed on each of these cost centers.

41 DIRECT CARE COST COMPONENT

The basis for reimbursement within the direct care cost component is a resident classification system that groups residents into classes according to their assessed conditions and the resources required to care for them.

41.1 Direct care costs include salary, wages, and benefits for:

41.11 registered nurses salaries/wages (excluding Director of Nursing),
41.12 licensed practical nurses salaries/wages,
41.13 nurse aides salaries/wages,
41.14 patient activities personnel salaries/wages,
41.15 ward clerks salaries/wages,
41.16 contractual labor costs,
41.17 fringe benefits for the positions in Sections 41.11 through 41.15 include:

41.17.1 payroll taxes,
41.17.2 qualified retirement plan contributions,
41.17.3 group health, dental, and life insurance, and

41.17.4 cafeteria plans.

41.18 Medical supplies, medicine and drugs that are supplied as part of the regular rate of reimbursement. See Maine Medical Assistance Manual, Section 67, Appendix #1. Excluded are costs that are an integral part of another cost center.

41.2 Resident assessments

The Resident Assessment Instrument (RAI) is the assessment tool approved by the Department of Human Services to provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. It is comprised of the Minimum Data Set currently specified for use by HCFA (hereinafter, referred to as "MDS") and the Resident Assessment Protocols (RAPs).

The MDS provides the basis for resident classification into one of 45 case mix classification groups. An additional unclassified group is assigned when assessment data are determined to be incomplete or in error. Resident assessment protocols (RAPs) are structured frameworks for organizing MDS elements and gathering additional clinically relevant information about a resident that contributes to care planning.

Per Health Care Financial Administration (HCFA) guidelines, all residents admitted to a Nursing Facility (NF), regardless of payment source, shall be assessed using the MDS.

41.21 Schedule for MDS submissions

Facilities shall submit all required MDS assessments and tracking forms according to HCFA guidelines.

41.22 Electronic Submission of the MDS Information

Should extraordinary conditions arise whereby the nursing facility is unable to submit electronically, a request to submit MDS information via diskette shall be submitted to the Bureau of Medical Services. This request must be made a minimum of five (5) days prior to the required date of submission of the MDS assessment data. Transmission of MDS information will be in accordance with standards and specifications established under HCFA guidelines.

41.23 Quality review of the MDS process

41.23.1 Definitions

(1) MDS Correction Form. The MDS correction form is a form specified by HCFA that allows for the correction of MDS assessment information previously submitted and accepted into the MDS central data repository. Facility staff identifies and determines the need for data correction. The MDS clinical process must be maintained under HCFA requirements. Corrections take two(2) forms:

(a) Modification: Information contained in the MDS central repository is inaccurate for an assessment and requires correction.

(b) Deletion: The facility determines the MDS was submitted in error and is wrong. The facility submits an MDS Correction Form requesting the inaccurate record be deleted from the database.

(2) "MDS assessment review" is a review conducted at nursing facilities (NFs) by the Maine Department of Human Services, for review of assessments submitted in accordance with Section 41.2 to ensure that assessments accurately reflect the resident's clinical condition.

(3) "Effective date of the Rate" is the first day of the payment quarter.

(4) "Assessment review error rate" is the percentage of unverified Case Mix Group Record in the drawn sample. Samples shall be drawn from Case Mix Group Record completed for residents who have Medicaid reimbursement. MDS Correction Forms received in the central repository or included in the clinical record will be the basis for review when completed before the day of the review and included as part of the resident's clinical record.

(5) "Verified Case Mix Group Record" is a NF's completed MDS assessment form, that has been determined to accurately represent the resident's clinical condition, during the MDS assessment review process. Verification activities include reviewing resident assessment forms and supporting documentation, conducting interviews, and observing residents.

(6) "Unverified Case Mix Group Record" is one which, for reimbursement purposes, the Department has determined does not accurately represent the resident's condition, and therefore results in the resident's inaccurate classification into a case mix group that increases the case mix weight assigned to the resident. Records so identified will require facilities to submit the appropriate MDS correction form and follow HCFA clinical guidelines for MDS completion. Correction forms received prior to calculating the rate setting quarterly index will be used in the calculation of that index.

(7) "Unverified MDS Record" is one, which, for clinical purposes, does not accurately reflect the resident's condition. Records so identified will require facilities to submit the appropriate MDS correction form and follow the HCFA clinical guidelines for MDS completion.

41.23.2 Criteria for Assessment Review

NFs may be selected for a MDS assessment review by the Department based upon but not limited to any of the following:

(1) The findings of a licensing and certification survey conducted by the Department indicate that the facility is not accurately assessing residents.

(2) An analysis of the case mix profile of NFs included but not limited to changes in the frequency distribution of their residents in the major categories or a change in the facility average case mix score.

(3) Prior resident assessment performance of the provider, including, but not limited to, ongoing problems with assessments submission deadlines, error rates, high percentages of MDS corrections or deletions, and incorrect assessment dates.

41.23.3 Assessment Review Process

(1) Assessment reviews shall be conducted by staff or designated agents of the Department.

(2) Facilities selected for assessment reviews must provide reviewers with reasonable access to residents, professional and non-licensed direct care staff, the facility assessors, clinical records, and completed resident assessment instruments as well as other documentation regarding the residents' care needs and treatments.

(3) Samples shall be drawn from MDS assessments completed for residents who have Medicaid reimbursement. The sample size is determined following the HCFA State Operations Manual (SOM) Transmittal 274, Table 1 "Resident Sample Selection".

(4) At the conclusion of the on-site portion of the review process, the Departments reviewers shall hold an exit conference with facility representatives. Reviewers will share written findings for reviewed records.

41.23.4 Sanctions

The Department shall compute the quarterly facility average case mix index, as described in Section 80.3 of these principles. Effective with assessment reviews on or after October 1, 2000, the following sanctions shall be applied to the allowable case mix adjusted direct care cost component for the subsequent quarter for all Medicaid residents of the facility, for which the following assessment review error rates are determined. Such sanctions shall be a percentage of the total direct care rate after the application of the case mix adjustments and upper limit.

(1) A 2% decrease in the total direct care cost component will be imposed when the NF assessment review results in an error rate of 34% or greater, but is less than 37%.

(2) A 5% decrease in the total direct care cost component will be imposed when the NF assessment review results in an error rate of 37% or greater, but is less than 41%.

(3) A 7% decrease in the total direct care cost component will be imposed when NF assessment review results in an error rate of 41% or greater, but is less than 45%.

(4) A 10% decrease in the total direct care cost component will be imposed when the NF assessment review results in an error rate of 45% or greater.

41.23.5 Failure to complete MDS corrections by the nursing facility staff within 7 days of a written request by staff of the Bureau of Medical Services may result in the imposition of the deficiency per

diem as specified in Principle 152 of these Principles of Reimbursement. Completed MDS corrections and assessments, as defined in Section 41.2, shall be submitted to the Department or its designee according to HCFA guidelines.

41.23.6 Appeal Procedures: A facility may administratively appeal a Bureau of Medical Services rate determination for the direct care cost component. An administrative appeal will proceed in the following manner:

(1) Within 30 days of receipt of rate determination, the facility must request, in writing, an informal review before the Director of the Bureau of Medical Services or his/her designee. The facility must forward, with the request, any and all specific information it has relative to the issues in dispute. Only issues presented in this manner and time frame will be considered at an informal review or at a subsequent administrative hearing.

(2) The Director of his/her designee shall notify the facility in writing of the decision made as a result of the informal review. If the facility disagrees with the results of the informal review, the facility may request an administrative hearing before the Commissioner or a presiding officer designated by the Commissioner. Only issues presented in the informal review will be considered at the administrative hearing. A request for an administrative hearing must be made, in writing, within 30 days of receipt of the decision made as a result of the informal review.

(3) To the extent the Department rules in favor of the facility, the rate will be corrected.

(4) To the extent the Department upholds the original determination of the Bureau of Medical Services, review of the results of the administrative hearing is available in conformity with the Administrative Procedures Act, 5 M.R.S.A. §11001 et seq.

41.3 Allowable costs for the Direct Care component of the rate shall include:

41.31 Direct Care Cost. The base year costs for direct care shall be the actual audited direct care costs incurred by the facility in the fiscal year ending in calendar year 1998 except for facilities whose Medicaid rates are based on proforma cost reports in accordance with Sections 80.6 and 80.7. All base year costs are subject to upper limits defined in Section 80.3.3.5.

43 ROUTINE COST COMPONENT

All allowable costs not specified for inclusion in another cost category pursuant to these rules shall be included in the Routine cost component subject to the limitations set forth in these Principles. The base year costs for the routine cost component shall be the audited costs incurred by the facility in the fiscal year ending in calendar year 1998, except for facilities whose Medicaid rates are based on proforma cost reports in accordance with Sections 80.6 and 80.7. All base year costs are subject to upper limits defined in Section 80.5.4.

43.1 Principle. All expenses which providers must incur to meet state licensing and federal certification standards are allowable.

43.2 All inventory items used in the provision of routine services to residents are required to be expensed in the year used. Inventory items shall include, but are not limited to: linen and disposable items.

43.3 Allowable costs shall also include all items of expense efficient and economical providers incur for the provision of routine services. Routine services mean the regular room, dietary services, and the use of equipment and facilities.

43.4 Allowable costs for the Routine component of the rate shall include but not be limited to costs reported in the following functional cost centers on the facility's cost report.

(a) fiscal services, (not to include accounting fees)
(b) administrative services and professional fees not to exceed the administrative and management ceiling,
(c) plant operation and maintenance including utilities,
(d) laundry and linen,
(e) housekeeping,
(f) medical records,
(g) subscriptions related to resident care,
(h) employee education, as defined in Section 43.42.9, except wages related to initial and on-going nurse aide training as required by OBRA,
(i) dietary,
(j) motor vehicle operating expenses,
(k) clerical,
(l) transportation, (excluding depreciation),
(m) office supplies/telephone,
(n) conventions and meetings within the state of Maine,
(o) EDP bookkeeping/payroll,
(p) fringe benefits, to include:
    (1) payroll taxes,
    (2) qualified retirement plan contributions,
    (3) group health, dental, and life insurance, and
    (4) cafeteria plans.
(q) payroll taxes,
(r) one association dues, the portion of which is not related to lobbying
(s) food, vitamins and food supplements,
(t) director of nursing, and fringe benefits,
(u) social services, and fringe benefits,
(v) pharmacy consultant, dietary consultant, and medical director.

See the explanations in Section 43.42.1 - 43.45 for a more complete description of allowable costs in each cost center.

43.42.1 Allowable Administration and Management Expenses.

43.42.11 Principle. A ceiling shall be placed on reimbursement for all compensation for administration and policy making functions and all expenses incurred for management and financial consultation, including accounting fees that are incurred by a related organization or the facility's operating company. Any compensation received by the individual who is listed as the administrator on the facility's license for any other services such as nursing, cooking, maintenance, bookkeeping and the like shall also be included within this ceiling.

This ceiling shall be increased quarterly by the inflationary factor as defined in Section 91 to reflect the rate of inflation from July 1, 1995 to the appropriate quarter. To establish the prospective rate for nursing facilities the administrative ceiling in effect at the beginning of a facility's fiscal year will apply to the entire fiscal year of that facility.

43.42.12 For fiscal years beginning on or after July 1, 1995, the statewide average professional accounting costs by bed size (0-30, 31-50, 51-100, over 100) will be included in the administrative and policy - planning ceiling. Only those reasonable, necessary and proper accounting costs which are appropriate to the operation of nursing facilities are considered allowable accounting costs and will be included in the determination of the state wide average.

43.42.2 Ceiling. The administration and policy-planning ceiling that is in effect as of July 1, 1995 is listed below. The ceiling shall be increased quarterly to reflect the rate of inflation from July 1, 1995, to the appropriate quarter.

*up to 30 beds: $37,772 plus $637 for each licensed bed in excess of 10;

*31 to 50 beds: $54,240 plus $545 for each licensed bed in excess of 30;

*51 to 100 beds: $67,432 plus $364 for each licensed be in excess of 50; and

*over 100 beds: $90,757 plus $273 for each licensed bed in excess of 100.

In the case of an individual designated as administrator in more than one (1) facility, the Department shall combine the number of beds in these facilities and apply one hundred and twenty percent (120%) of the above schedule. The total allowance will be prorated to each facility based on the ratio of the facility's number of beds to the combined number of beds for all facilities under the direction of the administrator.

43.42.3 Administration Functions. The administration functions include those duties which are necessary to the general supervision and direction of the current operations of the facility, including, but not limited to, the following:

43.42.3.1 Central Office operational costs for business managers, controllers, reimbursement managers, office managers, personnel directors and purchasing agents are to be included in the administrative and policy-planning ceiling according to an allocation of those costs on the basis of all licensed beds operated by the parent company.

43.42.3.2 Policy Planning Function. The policy planning function includes the policy-making, planning and decision-making activities necessary for the general and long-term management of the affairs of the facility, including, but not limited to the following:

a) financial management, including accounting fees
b) establishment of personnel policies
c) planning of resident admission policies
d) planning of expansion and financing

43.42.3.3 This ceiling is not to include any Director of Nursing, Dietary Supervisor, or other department head, whose prime duties are not of an administrative nature but who may be responsible for hiring or purchasing for their Department.

43.42.3.4 All other regulations specific to administrative functions in Nursing Facilities that are included in State Licensing Regulations and all other State and Federal regulations.

43.42.4 Dividends and Bonuses. Bonuses, dividends, or accruals for the express purpose of giving additional funds to the administrator or owners of the facility, whether or not they are part of the administrative and management ceiling, will not be recognized as allowable costs by the Department.

43.42.5 Management fees. Management fees charged by a parent company or by an unrelated organization or individual are not allowable costs and are not considered part of the administrative and management ceiling.

43.42.6 Corporate Officers and Directors. Salaries paid to corporate officers and directors are not allowable costs unless they are paid for direct services provided to the facility such as those provided by an administrator or other position required by licensing regulations and included in the staffing pattern which are necessary for that facility's operation.

43.42.7 Central Office Operational Costs. Central office bookkeeping costs and related clerical functions that are not included in the administration and policy-planning ceiling may be allocated to each facility on the basis of total resident census limited to the reasonable cost of bookkeeping services if they were performed by the individual facility.

43.42.7.1 All other central office operational costs other than those listed above in this principle are considered unallowable costs.

43.42.8 Laundry services including personal clothing for Medicaid residents.

43.42.9 Cost of Educational Activities

43.42.9.1 Principle. An appropriate part of the net cost of educational activities is an allowable cost. Appropriate part means the net cost of the activity apportioned in accordance with the methods set forth in these Principles. Expenses for education activities may be evaluated as to

appropriateness, quality and cost and may or may not be included as an allowable cost based on the findings.

43.42.9.2 Orientation, On-the-Job Training, In-Service Education and Similar Work Learning. Orientation, on-the-job training, in-service education and similar work learning programs are not within the scope of this principle but, if provided by a staff person, are recognized as normal operating costs for routine services in accordance with the principles relating thereto.

43.42.9.3 Basic Education. Educational training programs which a staff member must successfully complete in order to qualify for a position or a job shall be considered basic education. Costs related to this education are not within the scope of reimbursement.

43.42.9.4 Educational Activities. Educational activities mean formally organized or planned workshops, seminars, or programs of study usually engaged in by the staff members of a facility in order to enhance the quality of resident care within the facility. These continuing education activities are distinguished from and do not include orientation, basic education programs, on-the-job training, in-service education and similar work learning programs.

43.42.10 Net Cost. The net cost means the cost of an activity less any reimbursement for them from grants, tuition and specific donations. These costs may include: transportation (mileage), registration fees, salary of the staff member if replaced, and meals and lodging as appropriate.

43.43 Motor Vehicle Allowance. Cost of operation of one motor vehicle necessary to meet the facility needs is an allowable cost less the portion of usage of that vehicle that is considered personal. A log which clearly documents that portion of the automobiles use for business purposes is required. Prior approval from the Division of Audit is required if additional vehicles are needed by the nursing facility.

43.44 Dues are allowed only if the nursing facility is able to provide auditable data that demonstrates what portion of the dues is not used for lobbying efforts by the agency receiving the dues payments.

43.45 Consultant Services. The following types of consultative services will be considered as part of the allowable routine costs and be built into the base year routine cost component subject to the limitations outlined in subsections 43.45.1 – 43.45.3.

43.45.1 Pharmacist Consultants

Pharmacist consultant fees paid directly by the facility in the base year, will be included in the routine cost component. In addition to any pharmacist consultant fees included in the base year rate, up to $2.50 per month per resident shall be allowed for drug regimen review.

43.45.2 Dietary Consultants

Dietary Consultants, who are professionally qualified, may be employed by the facility or by the Department. The allowable amounts paid by the nursing facility to Dietary Consultants in the base

year, when reasonable and non-duplicative of current staffing patterns, will be included in the routine cost component.

43.45.3 Medical Directors

The base year cost of a Medical Director, who is responsible for implementation of resident care in the facility, is an allowable cost. The base year allowable cost will be established and limited to $1,200.

43.5 Principle. Research Costs are not includable as allowable costs.

43.6 Grants, Gifts, and Income from Endowments

43.61 Principle. Unrestricted grants, gifts and income from endowments should not be deducted from operating costs in computing reimbursable costs. However, unrestricted Federal or State grants or gifts received by a facility will be used to reduce the operating costs of that facility. Grants, gifts, or endowment income designated by a donor for paying specific operating costs should be deducted from the operating costs or group of costs.

43.61.1 Unrestricted grants, gifts, income from endowment. Unrestricted grants, gifts, and income from endowments are funds, cash or otherwise, given to a provider without restriction by the donor as to their use.

43.61.2 Designated or restricted grants, gifts and income from endowments. Designated or restricted grants, gifts and income from endowments are funds, cash or otherwise, which must be used only for the specific purpose designated by the donor. This does not refer to grants, gifts or income from endowments which have been restricted for a specific purpose by the provider.

43.62 Donations of Produce or Other Supplies. Donations of produce or supplies are restricted gifts. The provider may not impute a cost for the value of such donations and include the imputed cost in allowable costs. If an imputed cost for the value of the donation has been included in the provider's costs, the amount included is deleted in determining allowable costs.

43.63 Donation of Use of Space. A provider may receive a donation of the use of space owned by another organization. In such case, the provider may not impute a cost for the value of the use for the space and include the imputed cost in allowable costs. If an imputed cost for the value of the donation has been included in the provider's cost, the amount included is deleted in determining allowable costs.

43.7 Purchase Discounts and Allowances and Refunds of Expenses.

43.71 Principle. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

43.71.1 Discounts. Discounts, in general, are reductions granted for the settlement of debts.

44 FIXED COSTS COMPONENT

44.1 All allowable costs not specified for inclusion in another cost category pursuant to these rules shall be included in the Fixed Cost component subject to the limitations set forth in these Principles. The base year costs for the fixed cost component shall be the costs incurred by the facility in the most recently audited fiscal year. Fixed Costs include:

44.1.1 depreciation on buildings, fixed and movable equipment and motor vehicles,
44.1.2 depreciation on land improvements and amortization of leasehold improvements,
44.1.3 real estate and personal property taxes,
44.1.4 real estate insurance, including liability and fire insurance,
44.1.5 interest on long term debt,
44.1.6 return on equity capital for proprietary providers,
44.1.7 rental expenses,
44.1.8 amortization of finance costs,
44.1.9 amortization of start-up costs and organizational costs,
44.1.10 motor vehicle insurance,
44.1.11 facility's liability insurance, including malpractice costs and workers compensation,
44.1.12 administrator in training,
44.1.13 water & sewer fees necessary for the initial connection to a sewer system/water system,
44.1.14 portion of the acquisition cost for the rights to a nursing facility license.

See the explanations in Sections 44.2 - 44.10 for a more complete description of allowable costs in each of these cost centers.

44.2 Principle. An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be:

44.2.1 Depreciation. Allowance for Depreciation Based on Asset Costs.

44.2.2 Identified and recorded in the provider's accounting records.

44.2.3 Based on historical cost and prorated over the estimated useful life of the asset using the straight-line method.

44.2.4 The total historical cost of a building constructed or purchased becomes the basis for the straight-line depreciation method. Component depreciation is not allowed except on those items listed below with their minimum useful lives:

Electric Components	20 years
Plumbing and Heating Components	25 years
Central Air Conditioning Unit	15 years
Elevator	20 years

43.71.2 Allowances. Allowances are deductions granted for damages, delay, shortage, imperfections, or other causes, excluding discounts and returns.

43.71.3 Refunds. Refunds are amounts paid back or a credit allowed on account of an over-collection.

43.72 Reduction of Costs. All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

43.73 Application of Discounts Purchase discounts have been classified as cash, trade, or quantity discounts. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required. In the past, purchase discounts were considered as financial management income. However, modern accounting theory holds that income is not derived from a purchase, but rather from a sale or an exchange, and the purchase discounts are reductions in the cost of whatever was purchased. The true cost of the goods or services is the net amount actually paid for them. Treating purchase discounts as income would result in an overstatement of costs to the extent of the discount.

43.74 All discounts, allowances, and rebates received from the purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. This treatment is equitable and is in accord with that generally followed by other governmental programs and third-party organizations paying on the basis of costs.

43.8 Principle. Advertising Expenses. The reasonable and necessary expense of newspaper or other public media advertisements for the purpose of securing necessary employees is an allowable cost. No other advertising expenses are allowed.

43.9 Legal Fees. Legal fees to be allowable costs must be directly related to resident care. Fees paid to the attorneys for representation against the Department of Human Services are not allowable costs. Retainers paid to lawyers are not allowable costs. Legal fees paid for organizational expenses, are to be amortized over a 60 month period.

43.10 Costs Attributable to Asset Sales. Costs attributable to the negotiation or settlement of a sale or purchase of any capital asset (by acquisition or merger) are not allowable costs. Included among such unallowable costs are: legal fees, accounting and administrative costs, appraisal fees, costs of preparing a certificate of need, banking and broker fees, good will or other intangibles, travel costs and the costs of feasibility studies.

43.11 Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost.